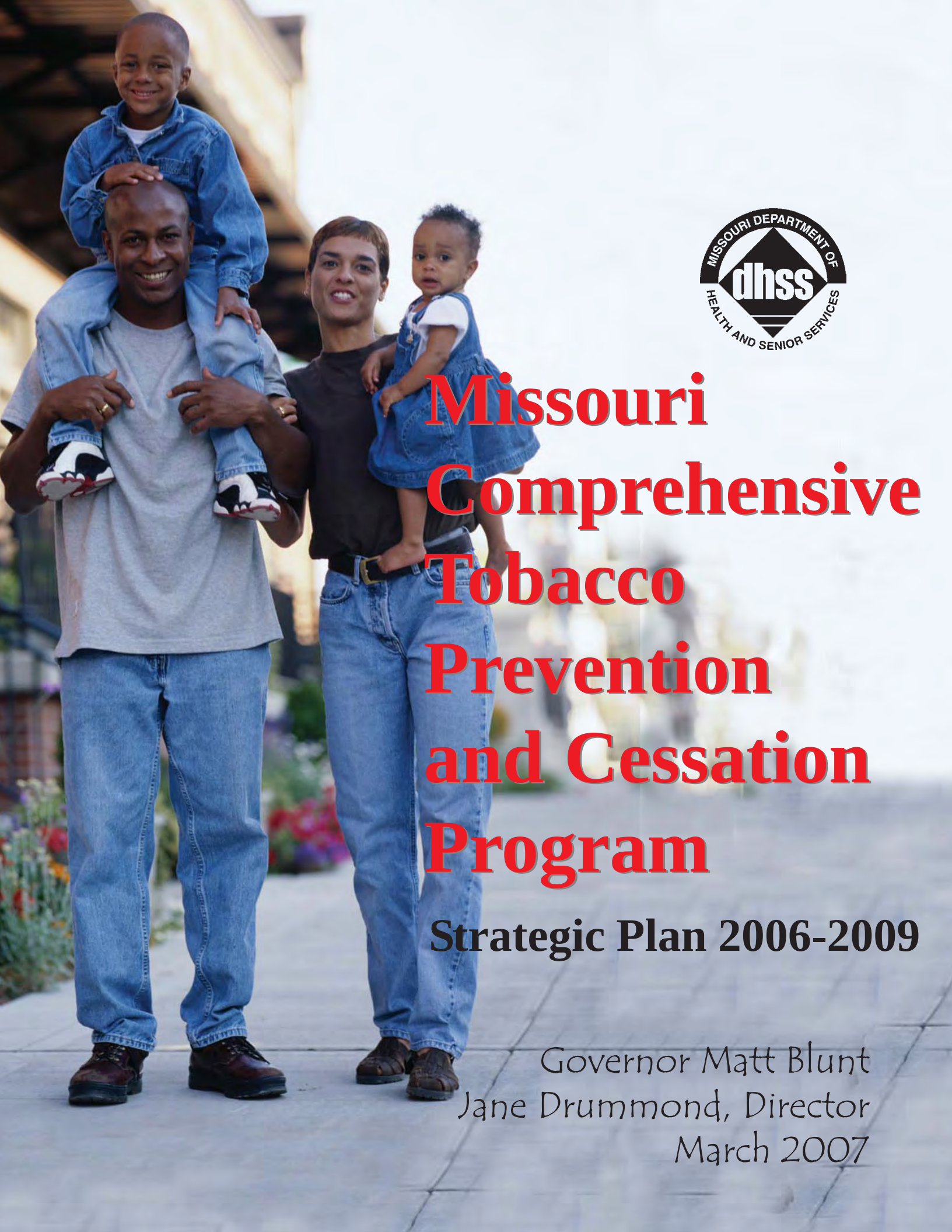

Missouri Comprehensive Tobacco Prevention and Cessation Program

Strategic Plan 2006-2009

Governor Matt Blunt
Jane Drummond, Director
March 2007

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
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Jane Drummond
Director

Matt Blunt
Governor

March 2007

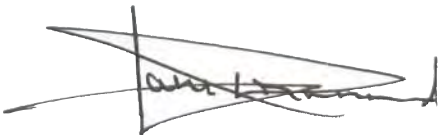
Dear Colleague:

Tobacco use is the leading cause of preventable death in Missouri. Unfortunately, almost 9,500 Missourians die from smoking-related illnesses each year. Not only does tobacco cost lives, it costs money. In Missouri, nearly $2 billion dollars were spent treating tobacco-related illnesses in 2002, including $512 million dollars of taxpayer funds to treat Medicaid beneficiaries.

The human and economic toll of tobacco use in Missouri can be significantly reduced if the strategies and actions in this plan are implemented. Thanks to a workgroup of public health professionals, *Missouri's Comprehensive Tobacco Use Prevention Program Strategic Plan* has been updated. Progress in addressing the goals in the 2003 plan is described. The goals, strategies and actions are expanded to address the current needs in the state. The plan truly reflects the vision of those working tirelessly each and every day to reduce the impact of tobacco use in Missouri.

It is hoped that all those working to reduce tobacco use and exposure to secondhand smoke will embrace the strategies and actions in this plan, and will take action to implement them.

Sincerely,



Jane Drummond
Director

Show-Me A Healthier Missouri: Missouri Comprehensive Tobacco Prevention and Cessation Program Strategic Plan 2006-2009 March 2007 Update

Jane Drummond, Director, Missouri Department of Health and Senior Services

Glenda R. Miller, Director, Division of Community and Public Health

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Missouri Comprehensive Tobacco Prevention and Cessation Program
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Appreciation is extended to the following individuals and the organizations they represented for contributing time, expertise and resources to serve as a member of the workgroup that updated Missouri's *Comprehensive Tobacco Use Prevention Program Strategic Plan 2003-2009.* The result of their efforts are reflected in a state-of-the-art plan that will effectively guide Missouri's Comprehensive Tobacco Prevention and Cessation Program for years to come.

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Jim Blaine, MD & Delores Joyce, Missouri Partnership on Smoking or Health

Stan Cowan, Missouri Department of Health and Senior Services, Bureau of Health Promotion

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Lorie Snyder, Kansas City Health Department

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Sandra Zanaboni, Polk County Health Department

Workgroup Support:

Tricia Schlechte, Missouri Department of Health and Senior Services, Director's Office

Janet Wilson, Facilitator, Missouri Department of Health and Senior Services, Bureau of Health Informatics

Missouri Comprehensive Tobacco Prevention and Cessation Program Strategic Plan 2006-2009 Update

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March 2007

In Missouri, tobacco use . . .

- is responsible for almost 9,500 deaths each year
- causes an estimated 1,155 deaths annually due to exposure to secondhand smoke
- results in overwhelming health care, disability, lost productivity and revenue--
  $2.4 billion annually in tobacco-caused productivity losses,
  $1.96 billion in total medical expenditures, and
  $490 million in Medicaid costs
- is reported by almost one in three Missouri high school students (30.7% in 2005)
- is estimated to cause 1,500 Missouri youth to become regular smokers each month
- will cause an estimated 150,000 of today's youth who continue to smoke to eventually die from smoking-related illness

- is reported by 23.4% of adults in Missouri making it among the highest adult smoking rates in the U.S. The national rate is 20.5% (2005)
- is reported at much higher levels for adults with less education (37.2% of those with less than a high school education compared to 12.2 % of college graduates in 2005)
- is reported at higher levels for those with lower incomes (34.9% of those earning less than $15,000 compared to 17.6% of those earning more than $50,000 in 2005)
- is taxed at one of the lowest rates in the country (The national average is $1.02/pack. Missouri's tax is 17 cents/pack and ranks 49th lowest in the country.)

Why a Comprehensive Program for Missouri?

Public health officials are faced with many challenges in our efforts to improve the health of all Missourians. One of the biggest challenges is to reduce the burden that tobacco use is placing on the health and economy in our state. Tobacco use in Missouri is responsible for almost 9,500 deaths each year [1], which equates to the loss of 26 valued Missourians every day. Those dying are our mothers, brothers, neighbors and friends who are prematurely losing years of life due to tobacco's addictive and health compromising properties.

The magnitude of the tobacco use problem prompted the Missouri public health and tobacco prevention community to unify efforts to address the enormous problem.

In 2002-2003 a steering committee was convened to create a plan to reduce tobacco use in Missouri. The plan, *Missouri's Comprehensive Tobacco Use Prevention Program 2003-2009*, was based on evidence from other states that have effectively reduced tobacco use. (The plan may be found at www.dhss.mo.gov/SmokingAndTobacco.)

In May 2006, a workgroup was formed to update the plan and expand on the strategies conceived earlier.

Effective strategies are incorporated into the plan, which points Missouri in the right direction for achieving five major goals:

1. ***Prevent tobacco use initiation among young people.***
2. ***Promote quitting among youth and adults.***
3. ***Decrease exposure to secondhand (environmental) tobacco smoke.***
4. ***Identify and eliminate tobacco-related disparities.***
5. ***Build and sustain an effective tobacco control program.***

It is clear that well-funded statewide tobacco-use prevention and cessation programs prompt sharp reductions in smoking among both adults and children and result in savings to treat tobacco-related illnesses. More than $1 million in savings was realized in Oregon during 2001 efforts to reduce smoking among pregnant women.[2] The comprehensive programs in California produced a savings of more than $3 for every $1 spent on prevention.[3] Tobacco-use preven-

tion efforts have also been shown to directly reduce state Medicaid program expenditures. For the average state, more than 14% of all its smoking-caused health care expenditures are paid for by the state's Medicaid program.[4]

The Centers for Disease Control and Prevention (CDC) estimates that Missouri's annual cost of an effective, comprehensive tobacco-prevention program would range from $32.8 to $91.4 million.[5] Based on the experience of effective programs in states such as California, Massachusetts, Oregon and Arizona, CDC identified the components of a comprehensive program as the following:

- **Community** programs that support local efforts to prevent youth from starting to smoke and increasing smokefree public places. *(Federal and private funds support programs in Missouri.)*
- **School** programs to educate youth about the health hazards of tobacco use and exposure to secondhand smoke. *(Federal and private funds support youth advocacy programs in over 100 Missouri schools.)*
- **Statewide** programs to provide training and technical support for organizations implementing programs to reduce tobacco use by youth and increase quitting. *(In Missouri, federal maternal and child health funds support health care provider training.)*
- **Counter-marketing** program to educate about health risks of tobacco use and to encourage those who smoke to quit.*(In 2005, $82,000 in federal funds was used for media campaigns to educate about secondhand smoke.)*
- **Cessation** programs that include physician screening and counseling, telephone cessation counseling, and increasing access to nicotine replacement therapies and medications through reduced costs. *(Missouri launched limited telephone counseling services on June 1, 2005, with CDC funding.)*
- **Chronic disease** programs for early detection and prevention of chronic diseases related to tobacco use.
- **Enforcement** programs to enforce Missouri laws prohibiting the selling of tobacco products to under-age youth. *(The Department of Mental Health and the Department of Public Safety receive approximately $480,000 from tobacco settlement funds for retailer education and enforcement activities.)*
- **Surveillance and evaluation** systems established to track program implementation and effectiveness (10% of total program funding). *(In 2002, state funds from the tobacco settlement were used to collect county-level information on tobacco use, beliefs and knowledge among 15,000 Missouri adults.)*
- **Administration & Management** to ensure accountability of program expenditures (5% of total program funding). *(DHSS has six professional staff supported by CDC funds who work with community coalitions statewide.)*

The Vision and Guiding Principles for Missouri's Program

Vision:

Create a healthier Missouri
by reducing the burden of tobacco, and
by reducing exposure to secondhand smoke.

Guiding Principles:

1. **Evidence-based strategies:** Use evidence-based approaches to increase the effectiveness and efficiency of the tobacco-use prevention program activities.

2. **Evaluation and accountability:** Emphasize evaluation of approaches in order to assess impact and ensure accountability of the program.

3. **Conflict of interest:** Ensure individuals, organizations and contractors have no conflict of interest regarding funding or ties with the tobacco industry.

4. **Inclusion:** Support a population-based approach that is inclusive of and sensitive to diverse populations and cultures.

5. **Collaboration and coordination:** Promote a systems-based approach that supports the coordination and collaboration between the state and local organizations and contractors.

6. **Comprehensive and sustainable program:** Promote a long-term, sustainable, comprehensive program consistent with that of the Centers for Disease Control and Prevention's (CDC) *Best Practices for Comprehensive Tobacco Control Programs*.

7. **Expertise:** Effectively utilize the scientific, public health, and community expertise of organizations and individuals throughout Missouri.

8. **Ethics:** Ensure that the Missouri Comprehensive Tobacco Use Prevention Program is implemented by individuals and organizations committed to the integrity of the plan.

9. **Communication:** Ensure information and materials are presented in a manner that is clearly understood and is effective in reaching the targeted population.

Program Goals, Outcomes, Objectives and Actions

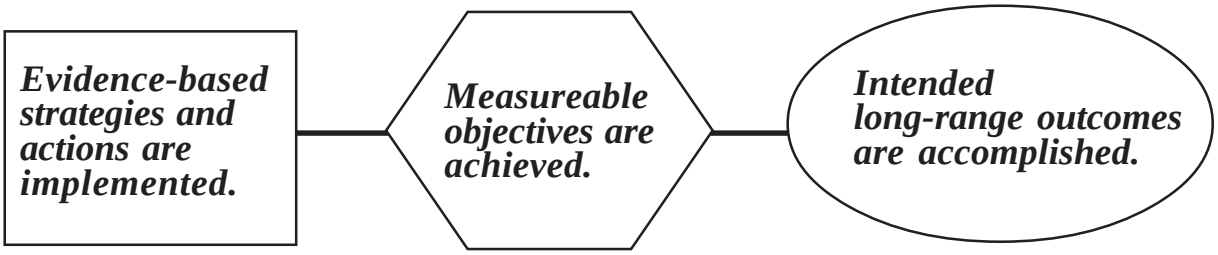
A guiding principle of Missouri's Program is to "use evidence-based approaches to assure that intended results are achieved." In 2001, the U.S. Task Force on Community Preventive Services issued a list of recommended evidence-based approaches for reducing tobacco use.[6] In May 2005, the CDC Office on Smoking and Health issued, "Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs" in which logic models with outcome indicators are provided for the following areas adopted for Missouri's program:

- Prevent tobacco-use initiation among young people.
- Promote quitting among young people and adults.
- Eliminate exposure to secondhand tobacco smoke.

Two additional goals were also adopted:

- Identify and eliminate tobacco-related disparities.
- Build and sustain an effective tobacco control program.

The relationship of the strategies, objectives and outcomes is best explained with the following logic model:

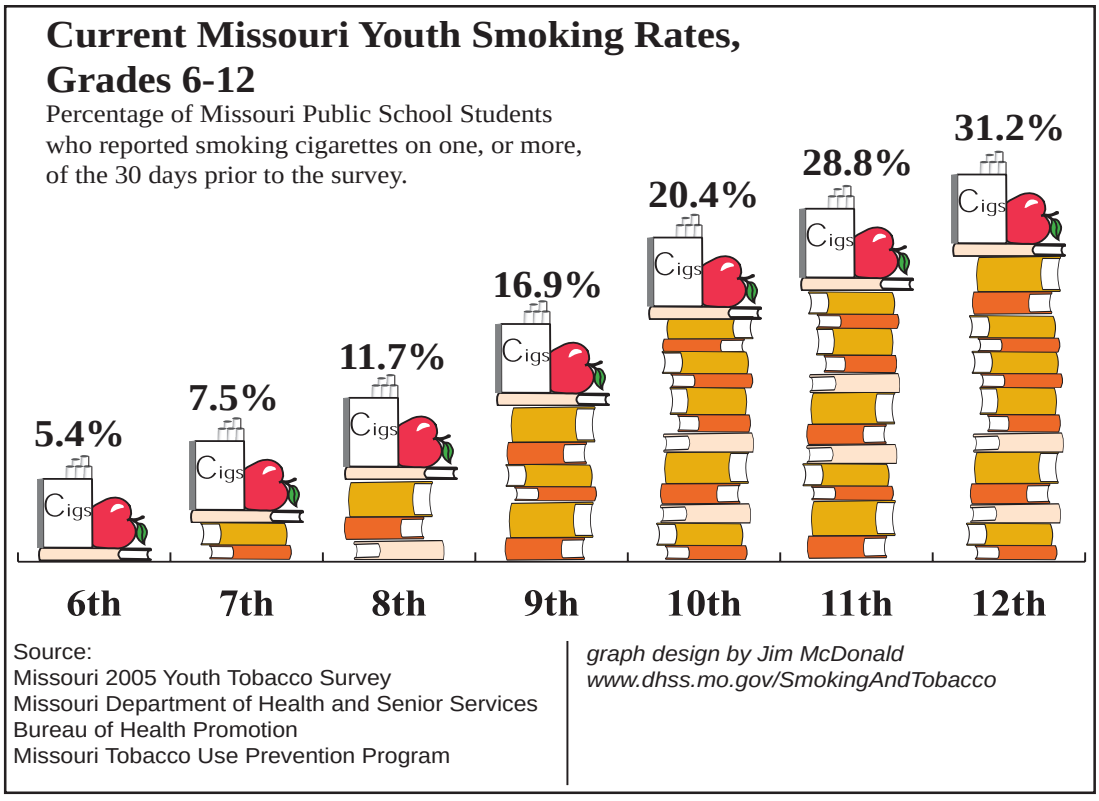


Progress in achieving outcomes and objectives since 2003 are provided at the end of each outcome or objective. Progress in implementing evidence-based strategies and actions since 2003 are summarized in Appendix D.

Goal 1: Prevent Tobacco-Use Initiation Among Young People

Rationale:

Early adolescence (ages 11-15, grades 6-10) is the period when most smokers tried cigarettes for the first time. The majority of adult smokers progressed to become regular smokers before the age of 18. Influences on young people to smoke include having parents or guardians who smoke or having parents with less than a high school education. Young people who misperceive smoking prevalence among adults and their peers tend to acquire approval of smoking behavior and are more likely to become smokers. Additionally, adolescents are more likely to smoke if they associate it with pro-social outcomes, such as having a positive image and bonding with a peer group. Other factors that may influence young people to try smoking include the media glamorizing the behavior, particularly among young women who want to be thin and think smoking will help them control their weight.[7]



Long-range Outcomes of Decreasing Initiation

- Decrease the percentage of students in grades 6-8 who first smoked a whole cigarette before the age of 11 from 30.5% (2001 YTS*) to 20% by 2009. (Progress: 26.8% on 2005 YTS) *Data sources are described on page 50.

- Decrease the percentage of students in grades 9-12 who first smoked a whole cigarette before the age of 13 from 22.7% (2001 YRBS) to 12% by 2009. (Progress: 14.8% on 2005 YRBS)

- Decrease the percentage of students in grades 6-8 who smoked on one or more of the previous 30 days from 8.8 % (2003 YTS) to 5% by 2009. (Progress: 8.3% on 2005 YTS)

- Decrease the percentage of students in grades 9-12 who smoked on one or more of the previous 30 days from 30.3 % (2001 YRBS) to 18.6% by 2009. (Progress: 21.3% on 2005 YRBS)

- Decrease the percentage of males in grades 9-12 who used some form of smokeless tobacco during the past 30 days from 18.6% (2001 YRBS) to 8.3% by 2009. (Progress: 11.5% on 2005 YRBS)

Strategy – Increase the price of tobacco products

Evidence:

Increasing the price of tobacco products is a highly effective and recommended intervention for reducing initiation of tobacco use by young people.[5-8]

Objectives:

1. Increase the percentage of adults who support increasing the tax on cigarettes if some or all of the money were used for tobacco-prevention programs from 60.7% (2003 CLS) to 70.0% by 2007. (Progress: No new data available)
2. Increase the cost of tobacco products in Missouri from an average $3.43 per pack to at least the national average of $4.40 per pack.

Actions:

1. Increase awareness among the public and policy makers about the evidence that increasing the price of tobacco products decreases initiation and use among youth.
2. Create support among the public and policymakers that funding prevention programs for youth with tobacco tax proceeds will produce an even greater reduction in use and is therefore a wise investment.
3. Advocate for state legislation to prevent manipulation of prices to offset the impact of tobacco tax increases on use by youth.
4. Advocate for state legislation to remove preemption of local governments' ability to impose or increase taxes on tobacco products.

Strategy – Increase pro-health knowledge, beliefs and skills among youth

Evidence:

Increasing the knowledge, beliefs and skills of young people to recognize and resist social influences to use tobacco, especially when combined with education to correct misperceptions about the prevalence of use, has been shown to decrease initiation of tobacco use among youth.[7-10] Mass media campaigns of an extended duration to inform and motivate young people to remain tobacco free are highly effective and strongly recommended when combined with other interventions.[6]

Objectives:

1. Increase the percentage of middle school students who reported they were taught about the dangers of tobacco use during the current school year from 57.8% (2003 YTS) to 60.0% by 2007. (Progress: 65.3% on 2005 YTS)
2. Increase the percentage of high school students who reported they were taught about the dangers of tobacco use during this school year from 38.8% (2003 YTS) to 42% by 2007. (Progress: 34.9% on 2005 YTS)

3. Increase the percentage of middle school students who during the past year participated in any community activities discouraging tobacco use from 21.0% (2003 YTS) to 25% by 2007. (Progress: 18.8% on 2005 YTS)
4. Increase the percentage of high school students who in the past year participated in any community activities to discourage tobacco use from 14.1% (2003 YTS) to 20% by 2007. (Progress: 12.2% on 2005 YTS)
5. Increase the percentage of middle school students who report their parents or guardians had discussed the dangers of tobacco use in the past 12 months from 63.4% (2003 YTS) to 65.0% by 2009. (Progress: 64.6% on 2005 YTS)
6. Increase the percentage of high school students who report their parents or guardians had discussed the dangers of tobacco use during the past 12 months from 57.7% (2003 YTS) to 60.0% by 2009. (Progress: 56.6% on 2005 YTS)

Actions:

1. Educate, encourage and assist schools to follow the CDC "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction," which includes recommendations to teach about the negative consequences of tobacco use, social influences, peer norms, resistance skills, and to provide training for teachers.
2. Assist schools and communities with organizing and training youth groups to effectively educate the public and their peers about the practices and influences of the tobacco industry and counter with pro-health messages. Enhance existing youth groups' effectiveness.
3. Identify effective messages for countering influences on youth to use tobacco and deliver messages through sustained earned and paid media campaigns.
4. Seek the assistance of community-based organizations and agencies serving youth not in traditional school settings (e.g., public schools) to assess for tobacco use and implement tobacco-use prevention programs and messages where appropriate.
5. Educate, train and encourage parents/guardians regarding the negative consequences of tobacco use, social influences, peer norms, and resistance skills to assist their children in refusing to use tobacco.
6. Establish and maintain collaborative relationships with educational leadership at the state and local levels to facilitate implementation of tobacco-prevention programs and policies in schools.

Strategy – Create tobacco-free environments

Evidence:

Creating tobacco-free school and community environments as a strategy for reducing young peoples' exposure to tobacco-promoting images, and as part of a comprehensive approach for tobacco-use prevention is recommended.[5, 7-10] Current evidence is insufficient to determine if school policies prohibiting tobacco use on school grounds alone results in reduced initiation and use by youth.[8]

Objectives:

1. Increase the proportion of secondary schools (grades 6-12) that prohibit students from wearing tobacco clothing or carrying tobacco company merchandise from 92% (2000 SHP) to 100% by 2008. (Progress: 94% on 2004 SHP)
2. Increase the percentage of public secondary schools that prohibit faculty and staff use of tobacco on school property (72% 2002 SHP) and at off-campus school-sponsored events (41% 2002 SHP) to 100% for all tobacco products by 2008. (Progress: 70% on school property and 40% off-campus on 2004 SHP)
3. Increase the percentage of public secondary schools that prohibit visitors from using tobacco on school property (59% 2002 SHP) and at off-campus school-sponsored events (41% 2002 SHP) to 100% by 2008. (Progress: 57% on school property; 40% at school-sponsored events on 2004 SHP)
4. Decrease the percentage of middle school never smokers who are susceptible to start smoking from 23.0% (2003 YTS) to 20.0% by 2009. (Progress: 22.0% on 2005 YTS)
5. Decrease the percentage of high school never smokers who are susceptible to start smoking from 19.1% (2003 YTS) to 18.0% by 2009. (Progress: 21.6% on 2005 YTS)

Actions:

1. Increase awareness among education and community officials of the benefits of creating tobacco-free environments for youth.
2. Encourage, educate and assist schools to follow CDC's "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction" that includes a recommendation to implement and enforce tobacco-free school zones.

3. Assist schools and communities with organizing and training youth groups to effectively advocate for tobacco-free school and community environments. Enhance existing groups' effectiveness.
4. Advocate for legislation for a tobacco-free Missouri.
5. Increase tobacco-free policies for all youth activities and events, and at venues where youth congregate (e.g., sporting events, amusement and other parks, malls).

Strategy – Decrease youth access to tobacco products through retail sales

Evidence:

Decreasing youth access to tobacco products through state and local laws prohibiting retail sales to minors is a recommended strategy as part of a comprehensive program for tobacco-use prevention.[5,7] Current evidence is insufficient to determine if decreasing access of tobacco through retail sales to minors alone results in reduced initiation or use among youth.[7-8]

Objectives:

1. Increase retailer compliance with no-sales-to-minors law from 89.0% (2002 DMH Synar) to 93% by 2009. (Progress: 93.6% in 2005)
2. Decrease the percentage of high school students under the age of 18 who report buying cigarettes from a store in the past 30 days from 19.6% (01 YRBS) to 15% by 2009. (Progress: 17.8% on 2005 YTS)

Actions:

1. Enhance retailer education about the state's no-sales-to-minors law.
2. Develop and encourage local ordinances/policies to enhance enforcement of the state's no-sales-to-minors law.
3. Monitor state legislation for attempts to pre-empt community efforts to prohibit sales of tobacco products to minors through stronger ordinances and enforcement.
4. Advocate for legislation for licensing and regulating all tobacco products.
5. Require retailers to place all tobacco products behind counters.
6. Advocate for legislation to prevent youth under age 18 from selling tobacco products.

Strategy – Decrease social acceptability of tobacco

Evidence:

Reducing the influence of tobacco industry practices is a recommended outcome of effective tobacco control programs.[11] Young people are three times more sensitive to tobacco advertising than adults, which tends to dilute the effect of media stories about the health risks of smoking and increases smoking among youth who approve of and identify with images in advertising.[11] According to the Federal Trade Commission, the tobacco industry spends billions annually to promote its products through advertising in retail stores and the media, as well as through sponsorship of public events, the arts, and other worthy causes.[12] Additionally, it is well documented that the tobacco industry influences policymakers through contributions and lobbying, which results in a more favorable, pro-tobacco policy environment.[13]

Objectives:

1. Increase the percentage of high school students who saw or heard anti-smoking commercials in the past 30 days from 82.9% (2003 YTS) to 87% by 2007. (Progress: 78.6% in 2005)
2. Increase the percentage of middle school students who saw or heard anti-smoking commercials in the past 30 days from 74.9% (2003 YTS) to 80% by 2007. (Progress: 69.3% in 2005)
3. Increase the percentage of secondary schools with policies prohibiting tobacco advertising through sponsorship of school events from 90% (2002 SHP) to 100% by 2008. (Progress: 90% in 2004)
4. Increase the number of news media stories about tobacco industry practices and political lobbying from x (no data available) to x by 2007.

Actions:

1. Identify effective messages for countering influences on youth to use tobacco and deliver messages through sustained earned and paid media campaigns.
2. Educate the public about manipulative and deceptive practices of the tobacco industry (e.g., product placement, lobbying, sponsorships, imagery in movies).
3. Increase policies to prohibit tobacco industry sponsorship of school and community activities and events.

Goal 2: Promote Quitting Among Youth and Adults

Rationale:

"Programs that successfully assist young and adult smokers in quitting can produce a quicker and probably larger short-term public health benefit than any other component of a comprehensive tobacco control program." [5 (pg. 24)] For smokers who quit before the age of 50, the risk of dying in the next 15 years is cut in half. [14] Numerous studies have demonstrated the cost effectiveness of a variety of interventions that resulted in successful cessation among tobacco users.[7] Smoking cessation interventions are even more cost effective than other commonly provided clinical preventive services such as mammography, colon cancer screenings, PAP tests, and treatment of mild to moderate hypertension and high cholesterol.[5] The cost savings from reduction of tobacco use as a result of implementing moderately priced, effective cessation interventions more than pay for themselves in three to four years.[15]

Long-range Outcomes of Quitting

- Increase the proportion of adult former smokers who have abstained from tobacco use for 6 months or longer from 95.6% (2003 CLS) to 98% by 2009. (Progress: No new data available)

- Decrease the percentage of adults who smoke cigarettes from 27.2% (2000 BRFSS) to 14.5% by 2009. (Progress: 23.4% on 2005 BRFSS)

- Decrease the percentage of students in grades 9-12 who smoked cigarettes on one or more of the previous 30 days from 30.3% (2001 YRBS) to 18.6% by 2009. (Progress: 21.3% on 2005 YRBS)

- Decrease the percentage of pregnant females who smoke during pregnancy from 18.3% (2001 Birth records) to 13.5% by 2009. (Progress: 18.13% in 2004)

- Decrease the number of packs of cigarettes sold in Missouri from 590,490,000 (2003 DOR) to 575,000,000 by 2009. (Progress: 609,601,256 in FY06)

Strategy – Increase the price of tobacco products

Evidence:

Increasing the price of tobacco products is a highly effective and recommended intervention for increasing quitting and reducing consumption among youth and adults.[5-7] For each ten percent increase in the price of cigarettes, the overall consumption will decrease by three to five percent, even more among young people.[14]

Objectives:

1. Increase the percentage of adults who support increasing the tax on cigarettes if some or all of the money were used for tobacco-prevention programs from 60.7% (2003 CLS) to 70.0% by 2007. (Progress: No new CLS data available)
2. Increase the cost of tobacco products in Missouri from an average $3.43 per pack to at least the national average of $4.40 per pack.

Actions:

1. Private and voluntary organizations will explore options for increasing the price of tobacco products. The national average for state tobacco excise tax is $1.02 per pack. At 17 cents per pack, Missouri's cigarette tax ranks second lowest among all states and territories.
2. Ensure a portion of the tax proceeds is secured for implementing a comprehensive tobacco-use prevention program in Missouri, including for a cessation program component, with the goal of attaining funding at a level recommended by Centers for Disease Control and Prevention.
3. After successfully increasing the state's tobacco taxes, continue educational efforts to produce ongoing accountability and support by the public and policymakers.
4. After successfully increasing the state's tobacco taxes, maintain the advocacy network to monitor implementation of the proposed constitutional amendment.

Strategy – Promote quitting by adult and youth tobacco users

Evidence:

"Tobacco dependence may best be viewed as a chronic disease with remission and relapse."[16 (p. 134)] Due to the addictive nature of nicotine, most people who stop smoking require multiple quit attempts and varying levels of interventions.[16] Mass media campaigns of extended duration using brief, recurring messages informing and motivating users to quit are strongly recommended when combined with other interventions.[6]

Objectives:

1. Increase the percentage of adult smokers who are seriously considering stopping smoking within the next six months from 61.6% (2003 CLS) to 65.0% by 2007. (Progress: No new data available)
2. Increase the percentage of adult smokers who are planning to stop smoking within the next 30 days from 26.1% (2003 CLS) to 30.0% by 2007. (Progress: No new data available)
3. Increase the percentage of adult smokers who are aware of assistance available to help them quit smoking from 59.3% (2003 CLS) to 65.0% by 2007. (Progress: No new data available)

4. Increase the percentage of adult smokers who think they would be very, or somewhat, successful in stopping smoking if they tried from 48.3% (2003 CLS) to 60.0% by 2007. (Progress: No new data available)
5. Increase the percentage of high school smokers who want to stop smoking from 56.4% (2003 YTS) to 60.0% by 2007. (Progress: 55.8% on 2005 YTS)
6. Increase the percentage of adult smokers who quit for one day or longer during the past 12 months because they were trying to quit from 46.8% (2000 BRFSS) to 52% by 2007. (Progress: 52% on 2005 BRFSS)
7. Increase the percentage of high school smokers who quit smoking at least once during the previous 12 months from 59.8% (2001 YRBS) to 75.0% by 2007. (Progress: 60.1% on 2005 YTS)

Actions:

1. Create and utilize earned (free) media to create demand for cessation services by developing key messages regarding the importance of quitting, and assistance available for those wanting to quit. Identify spokespersons in all areas of the state to deliver the messages to local media.
2. Implement a well-funded, paid statewide media campaign to create demand for cessation services, including quitline counseling. Tailor messages for specific populations to counter tobacco-industry marketing.
3. Develop tailored messages to reach specific populations not currently accessing cessation services as determined by usage data.
4. Develop and disseminate through existing networks and community coalitions materials tailored for use by employers and health systems to create demand for cessation services, including quitline counseling.
5. Require tobacco retailers to visibly display information about the Missouri Tobacco Quitline.
6. Promote increases in quitting as a benefit of creating tobacco-free policies and laws.

Strategy – Increase health care provider counseling to tobacco users

Evidence:

Health care system interventions to prompt health care providers to assess for tobacco use and counsel users to quit are effective and strongly recommended.[6] Health care providers counseling patients, including giving brief advice to quit, is effective and strongly recommended.[5-7]

Objectives:

1. Increase the percentage of adult smokers who were advised by a doctor, nurse or other health professional to quit smoking from 63.7% (2003 CLS) to 70.0% by 2007. (Progress: No new data available)
2. Increase the percentage of adult smokers who were advised to quit smoking by a health professional and also prescribed or recommended NRT or medication to help them quit from 35.5% (2003 CLS) to 40.0% by 2007. (Progress: No new data available)
3. Increase the percentage of adult smokers who were advised to quit smoking by a health professional and were also encouraged to use a cessation program, quit line or counseling to help them quit from 14.7% (2003 CLS) to 25.0% by 2007. (Progress: No new data available)
4. Increase the percentage of adult smokers who were advised by a dentist to quit smoking from 5.4% (2003 CLS) to 10.0% by 2007. (Progress: No new data available)

Actions:

1. Secure funding for provider reimbursement for cessation counseling, especially for Medicaid recipients, by working with state officials and health plans. Make the business case for cost-benefit of cessation counseling by health care providers in helping smokers to quit.
2. Work with Primaris to periodically update a provider cessation toolkit that includes Missouri Tobacco Quitline promotional information.

3. Disseminate cessation toolkits to providers for use in counseling patients that includes prompts to remind providers to use the 5A's brief cessation counseling, recommended pharmacotherapy for patients, referral information for quitline or other counseling services, and suggestions for follow-up or after care to prevent relapse.
4. Explore legislation to require Medicaid, health plans and individual businesses to reimburse providers for cessation counseling.
5. Expand professional development for providers to increase knowledge and skills for counseling patients who smoke to quit by implementing recommendations of the Clinical Practice Guidelines for Tobacco Use and Dependence. Include in the training information about the effectiveness of pharmacotherapies in helping smokers to quit.
6. Convene medical and health care associations to discuss standardized protocol for clinic screening systems to assess patient tobacco use and counseling to quit.
7. Identify best practices among health care systems for cessation counseling and follow-up care to share with others through newsletters, list serves, and websites.
8. Explore innovative approaches for increasing brief cessation counseling by health care providers.

Strategy – Increase available, affordable and accessible cessation services

Evidence:

Pharmacological treatment of nicotine addiction (including the use of the nicotine patch and gum) is effective and strongly recommended.[5-7, 16] Reducing patient out-of-pocket costs for effective cessation therapies is an effective and recommended strategy for reducing barriers for users who want to quit.[5-7, 16] Multi-component pro-active patient telephone supports (e.g., Quit lines) are effective and strongly recommended when combined with other interventions, such as mass media campaigns and/or therapies.[6-7, 16]

Objectives:

1. Increase the availability of pro-active tobacco quitline services from three priority populations (pregnant women, Medicaid beneficiaries and uninsured in state fiscal year 2005-2006) to all tobacco users by 2007.
2. Increase the availability of evidence-based cessation and education programs for youth, especially those that violate the state law prohibiting tobacco possession by youth under age 18 (Baseline to be established).
3. Increase the proportion of insurance purchasers and payers (public and private) that reimburse for tobacco-cessation services. (No data available)
4. Increase the percentage of current adult smokers who used a nicotine patch, nicotine gum or other medication to help them quit for one day or longer during the past twelve months from 14.3% (2003 CLS) to 25% by 2007. (Progress: No new data available)
5. Increase the percentage of current adult smokers who sought other assistance for quitting such as through classes or counseling the last time they tried to quit from 2.8% (2003 CLS) to 10.0% by 2007. (Progress: No new data available)
6. Increase the proportion of adult tobacco users who register for cessation services from the Missouri Tobacco Quitline from x% in state fiscal year 2005-2006 to x% by 2007.
7. Increase the percentage of high school smokers who participated in a program to help them quit smoking from 6.8% (2003 YTS) to 15.0% by 2007. (Progress: 6.0% on 2005 YTS)

Actions:

1. Secure funding to maintain, expand and evaluate effectiveness of the Missouri Tobacco Quitline proactive counseling services. Secure funding by making the business case for the cost-benefit of quitline services.

2. Work with health plans, employers, and state officials to secure funding for reducing smokers' out-of-pocket expense for cessation aids (especially for Medicaid recipients), including pharmacotherapy (prescription and over-the counter) and individual and group counseling. Make the business case for the cost-benefit of cessation aids in helping smokers to quit.
3. Advocate for legislation to require Medicaid and health plans to cover pharmacotherapies, including over-the-counter nicotine replacement therapy (NRT).
4. Maximize health care provider referrals to the Missouri Tobacco Quitline by increasing promotion of the fax referral system. Seek funding for reimbursement for fax referrals by making the business case for cost-benefit of quitline services.
5. Implement measures to ensure access to and use of Missouri Tobacco Quitline services by providing private locations from which patients may make calls in medical practices, clinics, hospitals, and local public health agencies.
6. Integrate and link cessation services to increase access and use – brief cessation counseling by providers, referrals to the Missouri Tobacco Quitline for free counseling, and access to free pharmacotherapies including over-the counter NRT. Require participation in pro-active quitline counseling program to receive free NRT if not covered by a health plan.
7. Identify and implement effective, accessible cessation-education programs and services for youth, especially for those who violate the state law prohibiting tobacco possession by youth under age 18.
8. Prompt actuarial analysis for smoking-related outcomes other than co-morbidity (e.g., cost of smoking-related auto accidents and house fires) to support the cost-benefit argument for cessation services.
9. Secure funding to implement surveillance and evaluation systems to measure the effectiveness of the cessation program component.

Goal 3: Decrease Exposure to Secondhand (Environmental) Tobacco Smoke

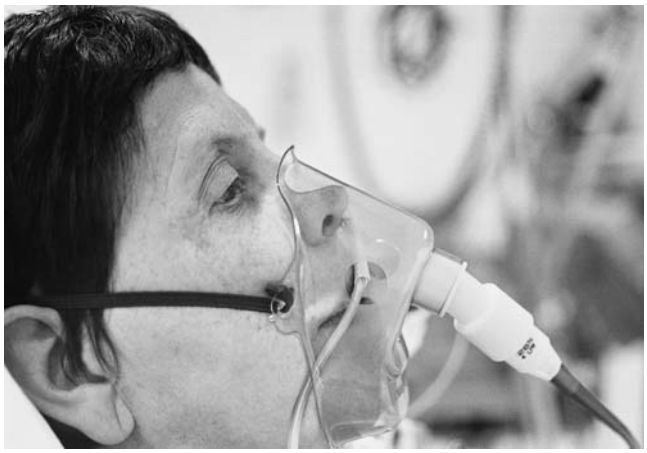
Rationale:

In 1986 and again in 2006, the U.S. Surgeon General concluded that secondhand smoke (SHS) is a cause of disease in nonsmokers.[17-18] Such diseases include the four top leading causes of death in Missouri: heart disease, lung cancer, stroke, and chronic obstructive pulmonary disease (emphysema and bronchitis).[19] These reports also found that children of smoking parents have an increased incidence of respiratory infections, bronchitis, pneumonia, middle ear infections, asthma, and SIDS. The 2006 report also noted that pregnant nonsmoking women exposed to SHS are at greater risk for low-birth weight deliveries. Additional recent studies conclude that SHS exposure in pregnant women slowed fetal growth, increased fetal mortality, and increased mutational effects on the unborn baby.[20-21] A comprehensive review of the respiratory effects of SHS by the Environmental Protection Agency (EPA) classified SHS as a known human carcinogen causing 3,000 lung cancer deaths each year among adult nonsmokers in the United States.[22] Exposure to SHS is responsible for the deaths of an estimated 1,200 Missourians every year.[23] State and local laws, as well as case law, require employers to protect the health of workers. Courts have ruled that employers must provide nonsmoking employees protection from proven health hazards of SHS exposure.

Long-range Outcomes for Decreasing Secondhand Smoke Exposure

- Decrease the percentage of adults who work indoors who are exposed to tobacco smoke in their work area from 17.7% (2003 CLS) to 8.0% by 2009. (Progress: No new data available)
- Decrease the percentage of middle school students who have never smoked that report having been in the same room with someone smoking cigarettes in the past seven days from 53.7% (2003 YTS) to 48% by 2009. (Progress: 44.8% on 2005 YTS)
- Decrease the percentage of high school students who have never smoked that report having been in a room with someone who smoked in the past seven days from 52.6% (2003 YTS) to 48% by 2009. (Progress: 57.2% on 2005 YTS)
- Decrease the percentage of adults who smoke cigarettes from 27.2% (2000 BRFSS*) to 14.5% by 2009. (Progress: 23.4% on 2005 BRFSS)
- Decrease the number of packs of cigarettes sold in Missouri from 590,490,000 (2003 Department of Revenue) to 575,000,000 by 2009. (Progress: 590,520,411 in 2005)

Strategy – Increase awareness of the health and economic costs of exposure to secondhand smoke



Evidence:

Levels of cotinine, a biomarker of secondhand smoke exposure, fell by 70% from 1988-91 to 2001-02 in the U.S. population.[24] This was attributed to a significant increase in strong smokefree policies and laws implemented during this period in literally hundreds of U.S. cities and 14 states. Even though more than 92% of Missourians believe that SHS is harmful to health, only 16% in the past year had asked a stranger to not smoke around them. Although 65% of Missourians indicated they would support smokefree ordinances for their communities, only one Missouri community has a strong smokefree workplace ordinance and only two communities have strong smokefree restaurant ordinances.[25]

Despite the decrease in cotinine levels, national surveys found 43 percent of nonsmokers still have detectable levels of cotinine and it is speculated nonsmokers in Missouri have levels higher than the national average.[26] The workplace is a primary source of SHS exposure among nonsmokers.[27] Employees working in workplaces with the least restrictive policies (e.g., service workers in bars and restaurants) are exposed at disproportionately higher levels of secondhand smoke.[28] Secondhand smoke in restaurants is approximately 1.6 to 2.0 higher than in office workplaces, and 4 to 6 times greater in bars.[29]

The Society of Actuaries estimated the total annual costs of excess medical care, mortality and morbidity due to SHS exposure (excluding economic losses related to pregnancy and the newborn) at over $5 billion in direct medical costs and over $5 billion in indirect costs.[30]

Objectives:

1. Increase the percentage of adults who think breathing smoke from other people's cigarettes is very harmful from 52.4% (2003 CLS) to 60% by 2007. (Progress: No new data available)
2. Increase the percentage of adults who in the past 12 months asked a stranger not to smoke around them from 16.2% (2003 CLS) to 25.0% by 2007. (Progress: No new data available)
3. Decrease the percentage of adults who work indoors who report someone smoked in their work area during the past seven days from 17.7% (2003 CLS) to 8.0% by 2007. (Progress: No new data available)

Actions:

1. Increase awareness among the public of the health and economic effects of secondhand smoke through a statewide education and media campaign.
2. Increase awareness among elected officials and policymakers of secondhand smoke issues and concerns through coordinated advocacy efforts.
3. Increase awareness among employers of the economic and health effects of secondhand smoke through specific educational campaigns and programs.
4. Identify groups disproportionately impacted by exposure to secondhand smoke and develop tailored messages to educate the public, policymakers and employers about the detrimental health effects experienced by these groups.
5. Expand and coordinate local capacity to increase awareness about the dangers of exposure to secondhand smoke.
6. Disseminate the evidence of the health and financial costs caused by secondhand smoke (e.g., the Surgeon General's report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke).*

Strategy – Reduce exposure to second-hand smoke in homes and vehicles

Evidence:

Almost 60% of U.S. children aged 3-11 years are exposed to second-hand smoke. Children exposed to SHS inhale the same cancer-causing substances and poisons as smokers, but because their bodies are developing, infants and young children are especially vulnerable to the poisons in SHS.[31]

Babies exposed to SHS, compared to babies not exposed, are more likely to die from sudden infant death syndrome; and have weaker lungs, which increases the risk for many health problems. Youth exposed to SHS have increased bronchitis, pneumonia, ear infections, and asthma attacks.[32]

11% of children aged 6 years and under are exposed to SHS in their homes on a regular basis (4 or more days per week). The likely major source of exposure to SHS for children is in homes and vehicles as parents are responsible for 90% of children's exposure to SHS.[33] Ignorance that SHS can cause these health problems or inadequate action in preventing these risks (e.g., cracking a window in the car while smoking) have contributed to the problem.

Objectives:

1. Increase the percentage of adults who do not allow smoking in their home from 58.8% (2003 CLS) to 65% by 2007. (Progress: No new data available)
2. Increase the percentage of adults who do not allow smoking in their vehicle from 53.9% (2003 CLS) to 60% by 2007. (Progress: No new data available)
3. Decrease the percentage of adults who had someone smoke in their house on one or more of the past seven days from 23.6% (2003 CLS) to 20% by 2007. (Progress: No new data available)
4. Decrease the percentage of adults who had someone smoke in their vehicle in the past seven days from x to x by 2007. (No data available)

Actions:

1. Develop and evaluate programs that educate families about the dangers of secondhand smoke in homes and vehicles.
2. Implement an educational campaign addressing the health effects of secondhand smoke in homes and vehicles. Include messages about available cessation assistance.
3. Increase awareness among landlords and condominium associations about the need for and benefits of smokefree lease agreements.
4. Advocate for legislation to prohibit smoking in vehicles when children are present.
5. Advocate for legislation to prohibit smoking in all forms of public transportation (e.g., cabs, buses).
6. Advocate for expanded legislation to prohibit smoking in childcare facilities, grounds and vehicles at all times.
7. Advocate for licensing requirements to provide smokefree environments for all children in state custody.

Strategy – Eliminate exposure to second-hand smoke in public places and work places

Evidence:

Often ventilation, air filtration or air cleaning devices are offered as a solution to accommodate both smokers and nonsmokers in the same area. After studying the matter, the American Society of Heating, Refrigerating and Air Conditioning Engineers issued a Position Document concluding the only means of effectively eliminating health risk associated with SHS exposure is to ban smoking activity; and that no other engineering approaches, including current and advanced dilution ventilation or air cleaning technologies, have been demonstrated or should be relied upon to control health risks from SHS exposure. Because of their mission to act for the benefit of the public, they encourage elimination of smoking in the indoor environment as the optimal way to minimize SHS exposure.[34]

Enforcement of laws and ordinances that prohibit smoking in worksites, public buildings, and other public places are highly effective in reducing nonsmokers' exposure to secondhand smoke and are strongly recommended.

Studies of indoor air quality samples obtained before and after enactment of ordinances for smokefree workplaces and public places have shown greater than 90% reduction in respirable particles and other air pollutants.[35]

The Surgeon General has determined that breathing SHS even a short time can have immediate adverse effects on the cardiovascular system and interferes with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of a heart attack. Further, nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing heart disease by 25 - 30 percent.[36]

Rather immediate benefits of smokefree ordinances for cardiovascular health were evidenced in two recent reports. Hospital admissions for heart attack were reported to decline by 40% in Helena, Montana and by 27% in Pueblo, Colorado; and were attributed to their ordinances for smokefree workplaces and public places.[37-38]

Such policies provide benefits to employees, as well. Three months after Lexington, Kentucky implemented their smokefree ordinance, the amount of cotinine in restaurant and bar workers decreased by 56% and they reported less colds and sinus infections.[39]

Objectives:

1. Increase the percentage of adults who think smoking should not be allowed at all in indoor dining areas of restaurants from 49.7% (2003 CLS) to 60.0% by 2007. (Progress: No new data available)
2. Increase the percentage of adults who think smoking should not be allowed at all in indoor shopping malls from 60.2% (2003 CLS) to 70.0% by 2007. (Progress: No new data available)
3. Increase the percentage of adults who think smoking should not be allowed at all in public buildings from 59.7% (2003 CLS) to 70.0% by 2007. (Progress: No new data available)
4. Increase the percentage of adults who think smoking should not be allowed at all in bars and cocktail lounges from 25% (2003 CLS) to 30% by 2007. (Progress: No new data available)
5. Increase the percentage of adults who think smoking should not be allowed at all in indoor sporting events and concerts from 62.0% (2003 CLS) to 70.0% by 2007. (Progress: No new data available)
6. Increase the percentage of adults who prefer a stronger workplace policy from 11.4% (2003 CLS) to 25% by 2007. (Progress: No new data available)

7. Increase the percentage of adults who describe their place of work's official smoking policy as not allowing smoking in any work areas from 74.4% (2003 CLS) to 80% by 2007. (Progress: No new data available)
8. Increase the number of public places and work places that adopt and enforce tobacco-free policies from x (2006 program tracking) to x by 2008.
9. Increase the number of municipalities that enact and enforce effective smoke-free ordinances from 3 (2006 Program tracking) to 10 by 2008.
10. Decrease the percentage of adults who work indoors who report someone smoked in their work area during the past seven days from 17.7% (2003 CLS) to 8.0% by 2007. (Progress: No new data available)

Actions:

1. Advocate for stronger enforceable state and local clean indoor air laws and ordinances.

2. Advocate for use of more accurate terms "clean air" or "smokefree" laws and ordinances rather than "smoking bans."

3. Develop model enforcement plans for state and local smokefree laws and ordinances.

4. Increase community capacity for establishing and enforcing clean indoor air policies and ordinances by providing resources and training for new and existing coalitions.

5. Identify and counter arguments against clean indoor air policies and ordinances, such as the perceived loss of customers by businesses that prohibit smoking.

6. Maintain a statewide tracking system for clean indoor air policies and ordinances adopted in communities.

7. Monitor state and local legislation for attempts to pre-empt adoption of clean indoor air policies and ordinances adopted in communities.

8. Increase awareness among employers about the need for stronger enforceable tobacco-free workplace policies.

9. Expose the tobacco industry's knowledge of the harm of secondhand smoke and their efforts to prevent effective laws and ordinances.

10. Advocate for tobacco-free correctional facilities.

11. Advocate for tobacco-free higher education campuses and vehicles.

12. Advocate for legislation to require that all cigarettes sold in Missouri be self-extinguishing.

Goal 4: Identify and Eliminate Tobacco-related Disparities

Rationale:

Tobacco-related disparities occur when a subgroup of a population uses tobacco at a rate disproportionately higher than other groups, or experience disproportionate disease outcomes as a result of tobacco use or exposure to secondhand smoke. Groups that experience disparities are often referred to as "at risk" and the terms are often used interchangeably.

The Tobacco-related Disparities Workgroup formed in 2004 (see Appendix for membership list) conducted a review of available state data and identified the most significant tobacco-related disparity to be among adults that have lower education levels (high school education or less) and earn less income (less than $15,000 annually) than the general adult population. Disparities were also identified among youth. Middle and high school students who smoked were much more likely than their non-smoking peers to live with someone who smoked, have friends who smoked, and be receptive to tobacco-industry advertising.[40]

According to the Centers for Disease Control and Prevention (CDC),[11] there is not a definitive evidence base for implementing programs that are intended to identify and eliminate tobacco-related disparities. That is not the case with efforts to reduce youth initiation, increase quitting, and eliminate exposure to secondhand smoke. Therefore, the CDC recommends that tobacco-related disparities be addressed by developing infrastructure and capacity at the state and local levels enabling tobacco-related disparities to be identified and addressed through the three program goal areas. Programs that are developed and implemented to address tobacco-related disparities should be thoroughly evaluated and findings submitted for publication to strengthen the limited literature base currently available. The strategies and actions offered by the Tobacco-related Disparities Workgroup support CDC's recommendation to build first capacity to address disparities. It is expected that this goal area will be greatly expanded as Missouri's Comprehensive Tobacco Prevention and Cessation Program evolves.

Long-range Outcomes for Identifying and Eliminating Tobacco-related Disparities

- Decrease smoking among adults earning less than $15,000 annual income from 34.9% (2000 BRFSS) to 30.0% by 2009.

Objectives:

1. Increase the percentage of low socio-economic status (SES) adult current smokers who were advised to quit smoking and also prescribed or recommended NRT or medications by a health professional from 29.8% (2003 CLS) to 34.0% by 2007.
2. Increase the percentage of low SES (<$15 k income) adult current smokers who used some form of medication the last time they tried to quit from 12.9% (2003 CLS) to 15.0% by 2007.

Strategy – Engage and empower communities to address tobacco-related disparities

Actions:

1. Identify key community leaders from disparate groups.
2. Assess needs and level of readiness of disparate groups to accept tobacco prevention and cessation assistance.
3. Secure relevant and current local data regarding tobacco-related disparities.
4. Identify and address sources of influence in the community that result in tobacco use among disparate groups.
5. Develop culturally oriented education focused on increasing awareness of tobacco-related health and economic disparities.

Strategy – Implement measurable tailored tobacco prevention and cessation strategies to address tobacco-related disparities

Actions:

1. Partner with funding entities and organizations to implement and/or integrate tobacco prevention curriculum specific to each disparate group.
2. Provide resources and technical assistance to communities for implementing local programs through a statewide network of community-based grants and contracts.
3. Identify factors that contribute to high prevalence of smoking in disparate populations and address through tailored messages and interventions.
4. Work with research entities to create interventions and measures to evaluate strategies specific to identified groups.
5. Strengthen enforcement of current laws and develop new effective laws that impact youth populations.
6. Identify and implement appropriate cessation strategies for disparate groups.

Goal 5: Build and Sustain an Effective Tobacco Control Program

Rationale:

To achieve the vision of creating a healthier Missouri by reducing the burden of tobacco and exposure to secondhand smoke, a comprehensive program must be developed, implemented and sustained. The Centers for Disease Control and Prevention (CDC) states, "An effective tobacco control program requires a strong management structure."[5] Furthermore, based on the experiences of states that have successfully implemented and sustained effective comprehensive programs, the CDC recommends that five percent of annual program funding be allocated to state program administration and management to ensure collaboration and coordination among tobacco control and public health partners.[5]

Based on best practices from other states, the Missouri Tobacco Prevention and Cessation Workgroup identified the following strategies and actions as necessary for building and sustaining an effective comprehensive program for the state.

Strategy – Establish an effective management structure for the program

Actions:

1. Establish the Missouri Department of Health and Senior Services as the coordinator of the Missouri Comprehensive Tobacco Prevention and Cessation Program Strategic Plan.
2. Propose that the Department of Public Safety, Division of Alcohol and Tobacco Control, be responsible for tobacco product licensing, regulating and collecting taxes in a manner consistent with alcohol control processes.
3. Recruit and develop qualified and diverse technical, program and administrative staff. Increase staff as needed for program expansion and improvement.
4. Dedicate staff for enforcement of tobacco control laws and ordinances.
5. Establish a system to award and monitor grants and contracts in a timely manner in accordance with state procurement requirements as appropriate.
6. Establish a system of technical assistance and training to increase the capacity of staff, contractors, grantees and partners in achieving program goals.
7. Develop an effective and regular communication strategy with contractors, grantees and other partners, including hosting annual statewide meetings.
8. Periodically review program activities to ensure consistency with the state's tobacco prevention and cessation strategic plan.

Strategy – Ensure a stable level of funding and staffing to implement effective tobacco control activities

Actions:

1. Advocate for allocation of tobacco Master Settlement Agreement funds for tobacco prevention, cessation and control.
2. Conduct educational meetings with state and local policymakers on the burden of tobacco in Missouri and the solutions for reducing the impact.
3. Actively communicate program activities, outcomes and successes to relevant constituencies (e.g., media, policymakers, health departments, the public).
4. Identify state and local leaders who can communicate the value of the program to the public, the media and policymakers.
5. Develop a sound fiscal management system.

Strategy – Strengthen local and regional partnerships

Actions:

1. Identify partnerships to implement the Missouri Tobacco Prevention and Cessation Program.
2. Establish and maintain local tobacco control coalitions.
3. Identify (inventory) local tobacco control programs and encourage collaboration and coordination to prevent duplication of efforts.
4. Establish a statewide network of local community-based grants and contracts to support local efforts.
5. Develop and implement a communication plan to ensure that partners are communicating and collaborating effectively.

Strategy – Implement statewide surveillance and evaluation activities for the program

Actions:

1. Establish and/or maintain ongoing surveillance systems that monitor tobacco-related deaths, diseases, behaviors and perceptions among Missourians.
2. Establish and implement an evaluation plan for the comprehensive program. Incorporate evaluation requirements for grants and contracts awarded for all program components.
3. Establish a system to compile and analyze data to identify and address tobacco-related disparities.
4. Collect baseline data to inform the needs of state and local tobacco-control enforcement to be more effective.
5. Use Missouri specific data to illustrate return on investment for investment in tobacco prevention, cessation and control.
6. Disseminate tobacco prevention, cessation and control research findings when available.
7. Establish a system to monitor tobacco industry activities (e.g., promoting products as reduced risk).
8. Create an annual report that details the activities and accomplishments of the comprehensive program.

Strategic Plan Implementation and Accountability Process

Implementation of the strategic plan will be accomplished through a coordinated action-planning effort by state and local tobacco-control partners. The partners will identify strategies and actions that each can implement through respective programs in their organizations and agencies. Action plans will be developed on an annual basis and progress in accomplishing the actions will be tracked.

The Missouri Department of Health and Senior Services will coordinate a surveillance and evaluation plan to track progress in meeting program strategies and objectives. Letters of commitment will be requested from each partner organization to ensure accountability in achieving the actions outlined in the plan.

Communication among partners will be facilitated through regular meetings or conference calls to ensure program coordination, sharing of information and successes, and resolution of problems that may be encountered in the implementation process. Progress will be reported by each organization at meetings of the partners.

Evaluation:

Providing a strong evaluation can be beneficial in managing and implementing a comprehensive plan, improving performance through data-based planning and helping to demonstrate accountability. Surveillance and evaluation data will form the basis for baseline measures, document the project's outcomes and successes, show that funds are being spent appropriately, and enable staff to identify effective approaches to continue so that resources are not wasted on ineffective interventions.

Evaluation will consist of process, short-term, intermediate and long-term outcome monitoring. Process evaluation will monitor implementation of interventions, population groups reached, program operations and effectiveness of local grants and contracts. Short-term and intermediate outcomes will be monitored for changes in awareness, knowledge, attitudes, beliefs, skills, social norms and policies related to tobacco-use prevention and control. Long-term outcomes will be monitored for changes in health behaviors and overall health status of Missourians (e.g., morbidity, mortality and health care costs).

APPENDIX A

Members of the Missouri Comprehensive Tobacco Use Prevention Program Statewide Steering Committee (2002-2003):

Rex Archer, M.D., M.P.H., & **Pat Morgester**, M.P.H., Kansas City Health Department
Mari Ann Bihr, M.Ed., Department of Elementary and Secondary Education
Deborah Boldt, M.P.A., Missouri Partnership on Smoking or Health
Bonnie Bowles, Missouri Association of Osteopathic Physicians
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Jim Caccamo, Ph.D., State Board of Senior Services
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Jim Davis, Ph.D., University of Missouri-Columbia
Dalen Duitsman, Ph.D., Ozarks Public Health Institute, Southwest Missouri State University, Springfield
Edwin Fisher, Ph.D., Washington University
Ollie Fisher, D.M.D., State Board of Health
Jay Goodman, American Cancer Society-Heartland Division
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Tom Holloway, Missouri State Medical Association
Bonnie Linhardt, American Heart Association-Heartland Affiliate
Jacob Lippert, D.D.S., Missouri Dental Association
Bernard Malone, M.P.A., Kansas City Health Department
Ann Mangelsdorf, Program Services, March of Dimes
Sherry Maxwell, Lincoln University Cooperative Extension
Ross McKinstry, M.S.P.H., Randolph County Health Department
Viviane McKay, M.P.H., & **Jacquelynn A. Meeks**, Dr.P.H., St. Louis County Department of Health
Melba Moore, M.S., & **Bruce Yampolsky**, M.P.A., City of St. Louis Department of Health
Lori Pickens, M.H.A., American Lung Association, Eastern Missouri
Leslie Porth, R.N., M.P.H., Missouri Hospital Association
Rev. B. T. Rice, M.I.S.S.I.O.N. NOW, St. Louis
Tricia Schlechte, M.P.H., B.S.N., Director's Office, DHSS
Steve Shimmens, Missouri Division of Liquor Control
Pam Victor, C.P.A., Division of Medical Services
Charles Williams & **Jamie Scott**, Missouri Department of Mental Health

APPENDIX B

Members of the Missouri State Cessation Workgroup (2004-2005):

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Regional Manager, Primaris

Barry Freedman, Vice-President of Community Initiatives,
American Lung Association of Missouri

Amy E. Gaier, Program Director,
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Jay Goodman, Senior Vice-President,
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Lynn Hebenheimer, Program Manager,
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Thomas L. Holloway, Director of Governmental Relations,
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Bonnie Linhardt, Public Advocacy Director,
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Jerry N. Middleton, MD,
American College of Obstetricians and Gynecologists, Missouri Section

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Director of Program Services, Missouri March of Dimes

APPENDIX C

Members of the Missouri Tobacco-related Disparities Workgroup (2005-2006):

Ms. Christine Molle
American Indian Council

Mr. Dean Anderson
SHAPE-University of Missouri Student Health Center

Ms. Yolanda Lorge
Grupo Latinoamericano

Toyin Sokari, MPH
National Cancer Institute's

Mr. Jerome Anderson, Executive Director
Boys & Girls Club of Missouri of The Capital City

Ms. Cathy Davis, RNCS, ANP
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Gwendolyn Randall, PECaD Coordinator
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Rev. C. William Chignoli, M. Div., Executive Director
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Mr. Charles Jackson

Ms. Cynthia Dean
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APPENDIX D

PROGRESS IN IMPLEMENTING STRATEGIES AND ACTIONS OF *MISSOURI'S COMPREHENSIVE TOBACCO USE PREVENTION PROGRAM STRATEGIC PLAN 2003-2009.*

Following is a summary of some activities conducted in the past three years to address the strategies and actions of the strategic plan prepared in 2002-2003. The summary is not inclusive of all activities that occurred across the state during this time.

GOAL 1: PREVENT TOBACCO USE INITIATION AMONG YOUNG PEOPLE

Strategy 1: Increase the price of tobacco products

Actions:

1. Increase awareness among the public and policymakers about the evidence that increasing the price of tobacco products decreases initiation and use among youth.
2. Create support among the public and policymakers that funding prevention programs for youth with tobacco tax proceeds will produce an even greater reduction in use and is therefore a wise investment.

Progress for Strategy 1:

- The "Show-Me Health" campaign funded by the Missouri Foundation for Health was implemented in spring 2005 by the American Lung Association for the purpose of educating Missourians about the need to increase Missouri's excise tax on cigarettes and other tobacco products.
- In early 2006, the Committee for a Healthy Future launched a voter petition initiative to place a proposed constitutional amendment on the November 2006 general election ballot to increase Missouri's excise tax on cigarettes by 80 cents and 20% on other tobacco products. If approved, the amendment would have earmarked approximately $61 million from the tax revenues to support a comprehensive tobacco use prevention and cessation program for the state. (Voter petition initiative was defeated November 2006.)

*Strategy 2: Increase pro-health knowledge, beliefs and skill*s

Actions:

1. Encourage and assist schools to follow the CDC "Guidelines for School Health Programs to Prevention Tobacco Use and Addiction" that includes recommendations to teach about the negative consequences of tobacco use, social influences, peer norms, resistance skills, and to provide training for teachers.

Progress for Action 1:

- Missouri Department of Health & Senior Services Tobacco Use Prevention Program staff assisted schools with implementing evidence-based curricula, such as Project TNT or Life Skills Training, that address the CDC recommendations.
- The Missouri Foundation for Health awarded a three-year grant to the University of Missouri Curators to implement a school-based program that focuses on character education, including social influences and resistance skills.

2. Assist schools and communities with organizing and training youth groups to effectively educate the public and their peers about the practices and influences of the tobacco industry and counter with pro-health messages. Enhance existing youth groups' effectiveness.

Progress for Action 2:

- Approximately 115 schools statewide have implemented Project Smokebusters supported by funding from a range of state and local partners, including the Missouri Department of Health & Senior Services, American Heart Association and the Missouri Foundation for Health.
- Approximately 80 schools implemented the American Lung Association's Teens Against Tobacco Use (TATU) program as a result of funding received from the Missouri Foundation for Health.
- The Students Working Against Tobacco (SWAT) youth advocacy program coordinated by Tobacco-Free St. Louis was implemented in 15 St. Louis area schools.
- The St. Louis County Health and Fitness Awareness Project supported by a contract with the Missouri Department of Health & Senior Services trained 2,800 youth in 6 schools to conduct education and advocacy activities in the community.
- The Health Care Foundation of Greater Kansas City provided grants to establish youth groups in schools, including support for Project Smokebusters in one school.

3. Identify effective messages for countering influences on youth to use tobacco and deliver messages through sustained earned and paid media campaigns.

Progress for Action 3:

- The Missouri Department of Health and Senior Services contracts with local public health agencies support local newspaper, radio and theatre ads directed at youth.
- Project Smokebusters supports radio and newspaper ads designed by youth that are directed at youth.
- Community Partnership of the Ozarks supports a TV, radio, and DVD message campaign directed at youth.
- Jefferson County Health Department implemented a local media campaign designed by youth that is directed at other youth.
- St. Louis' SWAT youth groups generate media messages directed toward other youth.
- St. Louis County's Health & Fitness Awareness Project supports the development of public services announcements by youth directed toward youth.

4. Seek the assistance of community-based organizations and agencies serving youth not in traditional school setters (e.g., public schools) to assess for tobacco use and implement tobacco use prevention programs and messages where appropriate.

   Progress for Action 4:
   - No progress due to lack of funding.

Strategy 3: Create tobacco-free environments

Actions:

1. Increase awareness among education and community officials of the benefits of creating tobacco-free environments for youth.

   Progress for Action 1:
   - Youth advocacy groups identified in Strategy 2, Action 2 made presentations to adult groups about the benefits of creating tobacco-free environments.
   - Missouri Show-Me State Games adopted a tobacco-free policy for all events.
   - Numerous communities across the state have adopted tobacco-free policies for venues where youth are present, such as parks and playgrounds, ball fields, swimming pools, etc.

2. Encourage, educate and assist schools to follow CDC's "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction" that includes a recommendation to implement and enforce tobacco-free school zones.

   Progress for Action 2:
   - Youth advocacy groups identified in Strategy 2, Action 2 make presentations to school administrators and boards advocating for tobacco-free school policies.
   - Federal legislation requiring schools to adopt a local wellness policy by the beginning of the 2006-2007 generated support for adopting tobacco-free school policies as part of the wellness policy. A partnership was created in spring 2005 among the Missouri Department of Elementary & Secondary Education, Missouri School Boards' Association, Missouri Department of Health & Senior Services, University of Missouri-Extension and other state and local partners to develop a model wellness policy for Missouri and to provide a coordinated network for training and technical assistance to schools.
   - Staff and contractors of the Missouri Department of Health and Senior Services provided technical assistance and information to assist schools in adopting tobacco-free policies.
   - The St. Louis University's Center for Tobacco Policy and Research developed a policy evaluation tool to assess the comprehensiveness of school tobacco policies. The tool was pilot tested using school policies from the St. Louis, Kansas City and Springfield areas. The information was made available to the schools to encourage policy improvement.

3. Assist schools and communities with organizing and training youth groups to effectively advocate for tobacco-free school and community environments. Enhance existing groups' effectiveness.

   Progress for Action 3:
   - Schools were provided assistance with organizing and training youth advocacy groups by a range of state and local partners (e.g, American Lung Association; American Heart Association; Missouri Foundation for Health; Missouri Department of Mental Health C-2000 coalitions; and Missouri Department of Health and Senior Services staff and contractors from St. Louis University, Ozarks Public Health Institute, and health departments in Kansas City, Independence, and Randolph, Jefferson, St. Louis, Douglas, Butler, Carter, Dunklin, Grundy, Marion, New Madrid, and Linn Counties.

Strategy 4: Decrease youth access to tobacco products through retail sales

Actions:

1. Enhance retailer education about the state's no-sales-to-minors law.

   Progress for Action 1:
   - Department of Public Safety conducts server training.
   - Department of Mental Health conducts retailer training.
   - Kansas City Health Department conducts Operation Storefront to educate retailers about tobacco sales to minors.

2. Enhance enforcement of the state's no-sales-to-minors law.

   Progress for Action 2:
   - Department of Mental Health conducts retailer compliance checks as required by the Synar amendment.
   - Department of Public Safety conducts surveillance and parking lot patrols for purchasers of tobacco products for minors.
   - Kansas City Health Department enforces the local ordinance based upon complaints.

3. Monitor legislative attempts to pre-empt community efforts to prohibit sales of tobacco products to minors.

   Progress for Action 3:
   - Missouri Partnership on Smoking or Health, American Lung Association, American Heart Association, and American Cancer Society lobbyists and partners monitor legislative activity for pre-emptive language.

GOAL 2: PROMOTE QUITTING AMONG YOUTH AND ADULTS

Strategy 1: Increase the price of tobacco products

Actions:

1. Increase awareness among the public and policymakers about the evidence that increasing the price of tobacco products decreases initiation and use among youth.
2. Create support among the public and policy makers that funding prevention programs for youth with tobacco tax proceeds will produce an even greater reduction in use and is therefore a wise investment.

Progress for Strategy 1:

- The "Show-Me Health" campaign funded by the Missouri Foundation for Health was implemented in spring 2005 by the American Lung Association for the purpose of educating Missourians about the need to increase Missouri's excise tax on cigarettes and other tobacco products.
- In early 2006, the Committee for a Healthy Future launched a voter petition initiative to place a proposed constitutional amendment on the November 2006 general election ballot to increase Missouri's excise tax on cigarettes by 80 cents and 20% on other tobacco products. If approved, the amendment would have earmarked approximately $61 million from the tax revenues to support a comprehensive tobacco use prevention and cessation program for the state. (Voter petition initiative was defeated November 2006.)

Strategy 2: Promote quitting by adults and youth tobacco users

Actions:

1. Conduct research to identify culturally appropriate effective messages to encourage tobacco users to quit.

Progress for Action 1:

- No funding was available to support this action. The National Cancer Institute provided the Missouri Department of Health & Senior Services with Consumer Health Profile information to guide decisions regarding targeted messages to promote the Missouri Tobacco Quitline.

2. Identify and counter tobacco industry messages that encourage certain population groups to use tobacco products.

Progress for Action 2:

- No funding was available to support this action.

3. Promote social supports for tobacco users to quit, such as by encouraging family and friends to support users' attempts to quit.

- The Missouri Tobacco Quitline provides free information to family and friends of tobacco users to assist in their efforts to encourage a loved one to quit.

Strategy 3: Increase health care provider counseling to tobacco users

Actions:

1. Encourage and assist health care systems to provide prompts for health care providers to assess for tobacco use, advise users to quit and refer for appropriate treatment.

   Progress for Action 1:
   - Primaris (the state's quality assurance organization for hospitals) disseminated widely a provider toolkit that included prompts for counseling patients about tobacco use. In 2006, the kit was updated and information about the Missouri Tobacco Quitline was included, including a fax referral form for use in referring patients to the Quitline.

2. Encourage health care providers to follow the "Treating Tobacco Use and Dependence Clinical Practice Guidelines."

   Progress for Action 2:
   - The Missouri Department of Health and Senior Services and University of Missouri-Columbia prepared a training program to assist health care providers with counseling patients that smoke to quit. To date, training has been provided for over 200 health care professionals statewide with more planned for the future.

Strategy 4: Increase available, affordable and accessible cessation services

Progress for Strategy 4:
- In June 2005, the Missouri Department of Health and Senior Services launched the Missouri Tobacco Quitline that provides free telephone cessation counseling to tobacco users. Physicians and family/friends of tobacco users may also call the quitline for information to assist patients and loved ones with quitting. The Quitline is operated by Free & Clear, Inc. and is supported with funding from the U.S. Centers for Disease Control and Prevention.

GOAL 3: DECREASE EXPOSURE TO SECONDHAND (ENVIRONMENTAL) TOBACCO SMOKE

Strategy 1: Increase awareness of the health and economic costs of exposure to secondhand smoke

Actions:

1. Increase awareness among the public, elected officials, policymakers, and employers of the economic and health effects of secondhand smoke exposure, challenging the perceived norm that exposure to others' tobacco smoke is not merely an annoyance but a health hazard.

   Progress for Action 1:
   - State and local programs and coalitions have conducted considerable education. The Missouri Department of Health and Senior Services (DHSS) Tobacco Use Prevention program in collaboration with local contractors and coalitions conducted annual paid media campaigns in 2004, 2005 and 2006 to educate about the health effects of secondhand smoke. Earned (free) media was also sought through news releases and economic studies that showed smokefree policies and ordinances do not result in lost revenues to businesses.
   - The release of the Surgeon General's Report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke"* in June 2006 provided important additional justification for implementing smokefree policies and laws, and is being used in education campaigns.
   - The "Show-Me Health" project included messages about exposure to secondhand smoke in earned media and educational campaigns.
   - The American Heart Association's "Go Red for Women" includes messages about exposure to secondhand smoke.
   - The University of Missouri-Columbia formed the Peers Against Secondhand Smoke (PASS) student group to conduct education.
   - Local media coverage was generated by coalitions in the St. Louis, Kansas City and Springfield areas working to educate the public.
   - Youth advocacy groups created public service announcements to increase awareness about exposure to secondhand smoke.

2. Identify groups disproportionately impacted by exposure to secondhand tobacco smoke and develop messages to educate the public, policymakers, and employers about the health effects experienced by these groups.

   Progress for Action 2:
   - State and local programs and coalitions provided education about the disparity experienced by service industry workers (e.g., waiters/waitresses) who work in restaurants, bars and casinos that allow smoking.

Strategy 2: Increase support for policies that prohibit smoking in public places

Actions:

1. Increase awareness among the public, elected officials, local law enforcement, and employers about the need to enforce existing state and local clean indoor air laws.

   Progress for Action 1:
   - Strong local ordinances were adopted in Maryville and Arnold (smokefree restaurants); and Ballwin, Columbia, Independence and Lee's Summit (smokefree workplaces) as a result of education conducted by local coalitions.
   - Kansas City adopted a workplace ordinance (with exemptions) and established an enforcement program for the new ordinance.
   - Unsuccessful attempts were made in Jefferson City (smokefree restaurant) and St. Louis County (smokefree workplace) to adopt ordinances that resulted in considerable public education about exposure to secondhand smoke.
   - All hospitals in the state will have tobacco-free campus policies in place by July 2007 as a result of a rule adopted by the Missouri Department of Health and Senior Services. Some hospital systems adopted policies prior to the rule change.
   - Tobacco-free campus policies were adopted by Ozark Technical College in 2005 and by State Fair Community College and St. Charles Community College in 2006.

2. Enhance community capacity for establishing and enforcing clean indoor air policies and ordinances by providing resources and training for new and existing coalitions.

   Progress for Action 2:
   - MDHSS, in collaboration with national, state and local partners, planned and conducted the following professional development opportunities to enhance community capacity:
   - March 2002 - Strengthening Tobacco Control Decision-making Strategies with CDC and support from the Tobacco Technical Assistance Consortium (TTAC).
   - June 2002 - Communities of Excellence in Tobacco Control: A Community Planning Guide with the American Cancer Society, Department of Mental Health, and support from TTAC.
   - March 2003 - Empowering Communities to Clear the Air of Secondhand Smoke with support from TTAC.
   - April 2003 - Six regional meetings on evidence-based policy and environmental interventions.
   - August 2003 - Evidence-based tobacco control: Segment in Introduction to Epidemiology CD ROM course with MHDSS Center for Local Public Health Services (CLPHS) and St. Louis University.

- September 2003 - Strengthening School Tobacco Control Policies with the Kansas City Health Department and CDC's Division of Adolescent and School Health.
- October 2003 - Best Practices: Earned Media Training for the Advanced Practitioner with the Missouri Partnership on Smoking or Health, Americans for Nonsmokers' Rights, and support from TTAC.
- November 2003 - Guide to Community Preventive Services teleconference with DHSS CLPHS.
- March 2004 - Earned Media Training for St. Louis Coalition members with the St. Louis University Tobacco Use Prevention Program.
- May 2004 - Social Marketing 101 with University of South Florida faculty and support from the (national) Directors of Health Promotion and Education.
- October 2004 - Fall workshop for Comprehensive Tobacco Use Prevention (CTUP) contractors and staff with focus on social marketing for tobacco control; lobbying constraints; and countering opposition arguments.
- April 2005 - Spring workshop for CTUP contractors and staff with focus on materials to encourage employers to adopt smokefree workplace policies; and economic impact of smokefree ordinances.
- April 2005 - Formative Research, a follow-up course to Social Marketing 101.
- May 2005 - Four regional meetings on chronic disease prevention through evidence-based policy and environmental interventions.
- September 2005 – School Wellness policy facilitator training that included tobacco policy recommendations.
- May 2006 – School Wellness policy regional workshops for school personnel to assist with adopting federally required wellness policy.
- May 2006 – Spring workshop for CTUP contractors and staff with focus on encouraging employers to adopt tobacco-free policies and to provide tobacco cessation assistance; and finding and using community economic data.

3. Identify and counter arguments against clean indoor air policies and ordinances, such as the perceived loss of customers by businesses that prohibit smoking.

   Progress for Action 3:
   - DHSS Tobacco Use Prevention Program staff and contractors generated a list of arguments and counter arguments for use by local coalitions working to increase local smokefree policies.
   - The DHSS Tobacco Use Prevention Program staff prepared a report of the impact of a smokefree restaurant ordinance adopted in Maryville in 2003 that demonstrated no loss of revenues in eating and drinking establishments following the implementation of the ordinance.

4. Maintain a statewide tracking system for clean indoor air policies and ordinances adopted in communities.

   Progress for Action 4:
   - The DHSS Tobacco Use Prevention Program established a database of smokefree workplace policies in the state, and also tracks adoption of ordinances adopted by municipalities.

5. Monitor state and local legislation for attempts to pre-empt adoption of clean indoor air policies and ordinances adopted in communities.

Progress for Action 5:

- The Missouri Partnership on Smoking or Health, American Cancer Society, American Heart Association and American Lung Association monitor legislation for pre-emptive language.

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CLS – (County-Level Study) Telephone survey of approximately 15,000 randomly selected adults over the age of 18 conducted for the first time in 2002-2003 by the DHSS.

BRFSS – (Behavioral Risk Factor Surveillance System) Annual telephone survey of randomly selected adults over the age of 18 conducted by the DHSS.

SHP – (School Health Profile) Survey of randomly selected public middle and high school (grades 6-12) principals and lead health education teachers conducted every even-numbered spring since 1994 by the Department of Elementary & Secondary Education.

YRBS – (Youth Risk Behavior Survey) Survey of randomly selected public high school students (grades 9-12) conducted every odd-numbered spring since 1995 by the Department of Elementary & Secondary Education.

YTS – (Youth Tobacco Survey) Survey of randomly selected public middle and high school students (grades 6-12) conducted by the DHSS in 2003 and 2005.

DMH Synar report – Report of retailer compliance with law prohibiting tobacco sales to minors completed annually by the Department of Mental Health Division of Alcohol and Drug Abuse.

Birth records – Data obtained from health care providers at the time of issuing a birth certificate for newborns.